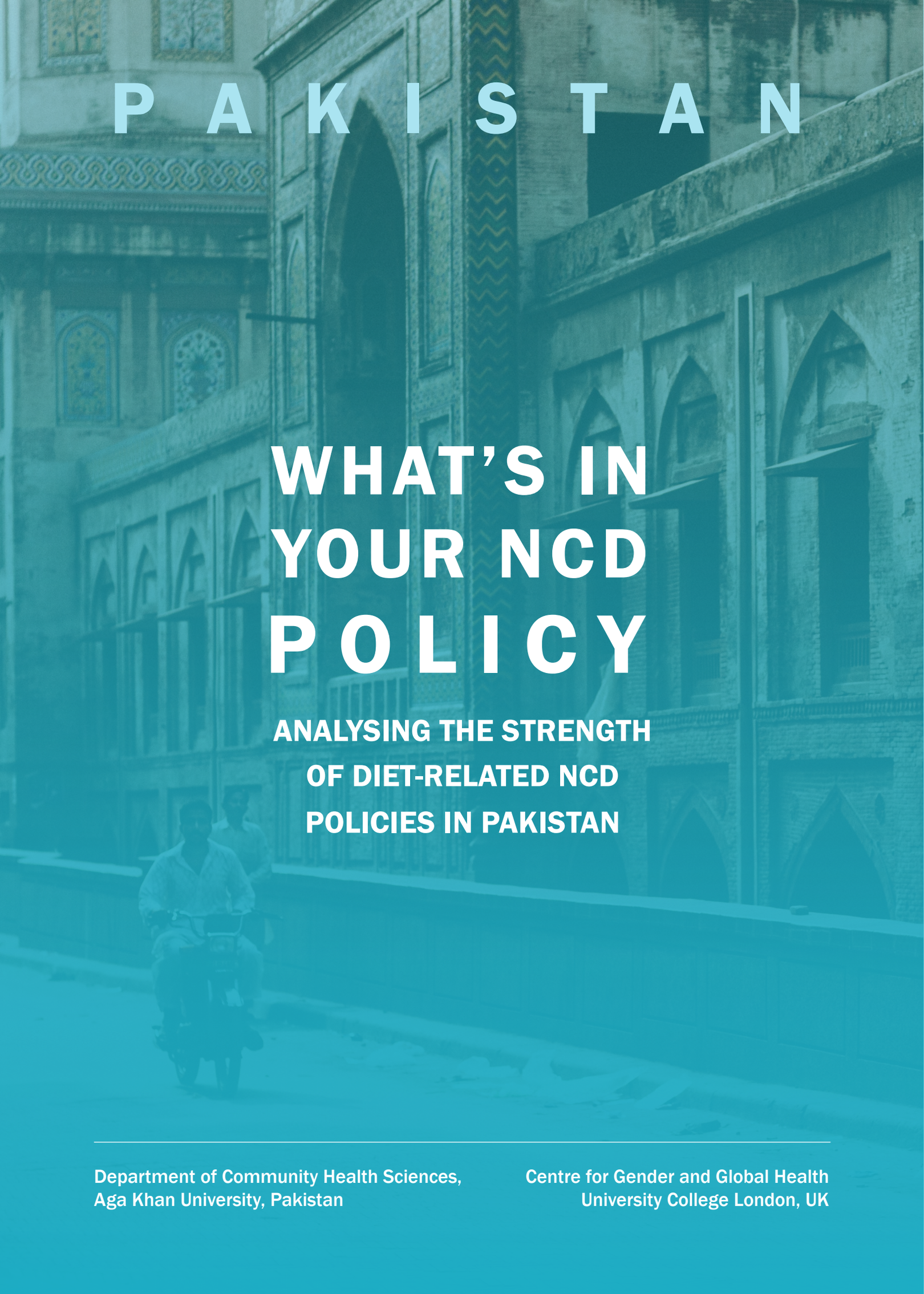

PAKISTAN

WHAT'S IN YOUR NCD POLICY

ANALYSING THE STRENGTH OF DIET-RELATED NCD POLICIES IN PAKISTAN

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The strength of national diet-related policies should match the severity of the burden of non-communicable diseases (NCDs) in Pakistan, and guide government action focused on the most critical dietary drivers and population groups at risk.

Yet, while Pakistan has recognised the importance of addressing NCDs, there has been no rigorous analysis to date of its country-level policies to tackle NCDs associated with unhealthy diets.

This brief presents an assessment of national policies and strategies related to promoting healthy diets and offers evidence-informed recommendations for shaping comprehensive, effective and equitable diet-related NCD policies.

The research presented has been conducted as part of a six-country study comparing national NCD policies to global recommendations, and evaluating the extent to which policies include effective and equitable attributes to improve population health. Study countries included Afghanistan, Bangladesh, Nepal, Pakistan, Tunisia and Vietnam.

Research in Pakistan was led by a team based at the Department of Community Health Sciences, Aga Khan University, Pakistan, in partnership with the Centre for Gender and Global Health, University College London.

The study was funded by the UK's Medical Research Council under grant number MR/P025188/1.

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NCDS IN PAKISTAN

Pakistan is currently facing a double burden of disease. The proportion of annual deaths attributed to non-communicable diseases (NCDs) is significantly greater than communicable diseases – 58% versus 35%.[1] Mortality rates due to NCDs – including cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – continue to rise, significantly hampering progress towards Sustainable Development Goal 3. Further, each day in Pakistan, approximately 100 people require amputations due to diabetes and trauma.[2] It is projected that between 2010 and 2025, nearly 4 million Pakistanis will lose their lives to NCDs.

FIG.1

NCDS ACCOUNT FOR FOUR OF THE TOP TEN CAUSES OF PREMATURE DEATH IN PAKISTAN – AND ARE ON THE RISE

Top 10 causes of years of life lost (YLLs) in 2017 and percent change, 2007-2017, all ages, number

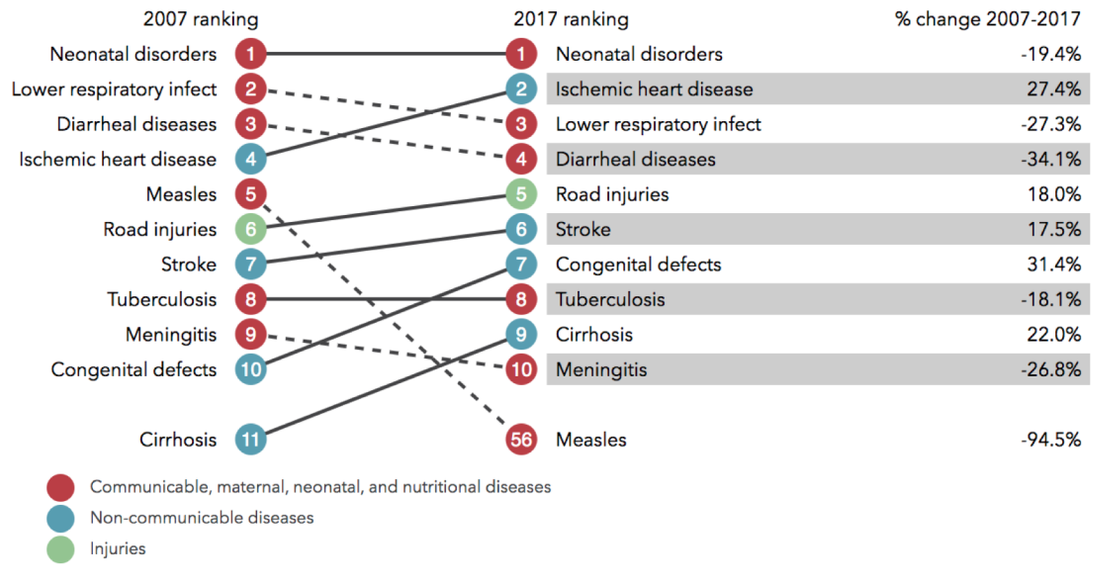
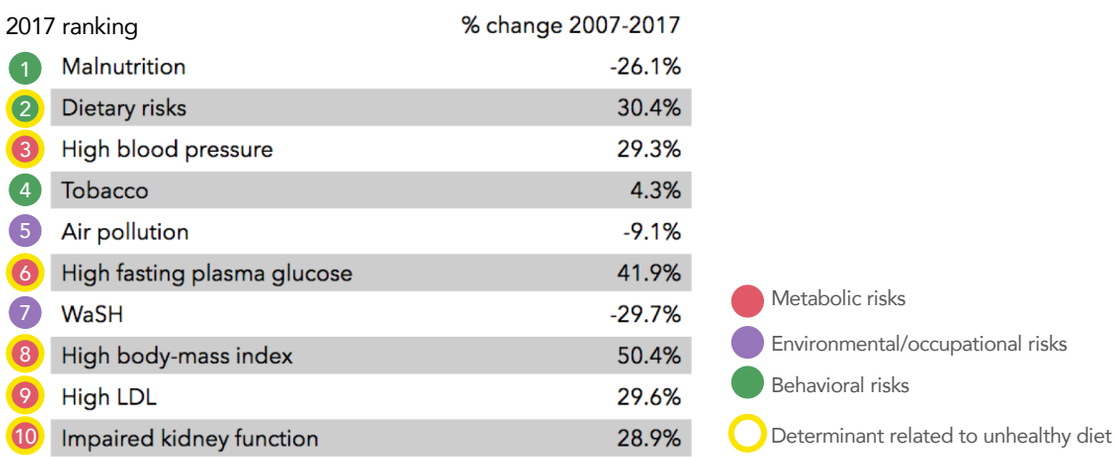


FIG.2

UNHEALTHY DIET IS AMONG THE MOST SIGNIFICANT – AND FASTEST GROWING – DETERMINANTS OF NCDS

Top 10 risks contributing to DALYs in 2017 and percent change, 2007-2017, all ages, number



Data for Figures 1 and 2 from Institute of Health Metrics and Evaluation, 2019: http://www.healthdata.org/pakistan

THE GLOBAL RESPONSE TO NCDS

Many interventions for the prevention and control of NCDs exist. Given the resource constraints facing all countries and their need to prioritise the most effective interventions, the World Health Organization (WHO) has identified a set of evidence-based "Best Buy" interventions that are not only highly cost-effective but also feasible and recommended for implementation in all countries.

Several of the Best Buys are explicitly aimed at addressing unhealthy diets.[3] These interventions are designed to mainly address the structural drivers and commercial determinants of diet, an approach likely to yield greater benefits at the population level compared to individually-focused interventions.[4,5]

NCDs: On the global agenda at last

While the burden of NCDs has been historically neglected by the global health community, prioritisation and action to prevent and address NCDs is expanding. The first UN General Assembly High-Level Meeting on NCDs in 2011 marked a critical turning point in mobilising political attention and policy action at national and global levels, as did the inclusion of an NCDs-related target in the Sustainable Development Goals (3.4, to reduce premature mortality from NCDs by one-third by 2030).

2%

OF ALL GLOBAL HEALTH FINANCING IS ALLOCATED TO NCDS

ACTION IN PAKISTAN

Strong political action to improve the dietary environment and address the growing burden of NCDs in the country is largely lacking. While the National Action Plan for Prevention and Control of NCDs and Health Promotion was formulated in 2004,[6] lack of government interest, budgetary constraints and frequent shifts in political leadership has stalled its implementation.

Additional challenges include a lack of civil society engagement on NCDs and limited data in the country (the STEPS survey has been conducted twice but restricted to just two provinces). Further, while the Ministry for National Health Services Regulation & Coordination has proposed a tax on tobacco and sugary beverages, it is yet to be approved by the Cabinet.

Pakistan Policy Analysis: Our research

During 2017-2019, we undertook an in-depth analysis of the Government's policy documents for controlling diet-related NCDs, and compared national responses to global recommendations for all countries. The purpose of the study was to identify where and how policy documents could be strengthened to more effectively address the growing burden of NCDs in the country.

POLICY DOCUMENT ANALYSIS: OUR QUESTIONS

THREE DIMENSIONS OF A ROBUST POLICY FRAMEWORK TO ADDRESS AND PREVENT NCDS

1 **COMPREHENSIVE:** ARE PAKISTAN'S NCD POLICIES CONSISTENT WITH GLOBAL RECOMMENDATIONS? [TABLE 1]

2 **EFFECTIVE:** DO PAKISTAN'S NCD POLICIES HAVE ADEQUATE AUTHORITY, ACCOUNTABILITY MECHANISMS AND BUDGET? [TABLE 1 & FIGURE 3]

3 **EQUITABLE:** DO PAKISTAN'S NCD POLICIES PROMOTE EQUITY AND HUMAN-RIGHTS BASED APPROACHES? [FIGURE 4]

OUR METHODS

We conducted an in-depth policy content analysis followed by stakeholder interviews. The content of policies inside and outside the health sector were reviewed to determine: (1) whether they were consistent with WHO Best Buys; (2) how much authority the policy has (e.g. whether it is national/provincial law or a sector strategic plan); (3) systems of accountability; (4) any associated budgetary line items; (5) the extent of attention paid to issues of equity (including gender) and human rights. We synthesised these findings into a "policy cube" to graphically present key features of the policy responses to combat diet-related NCDs (see page 6).

In-depth interviews (IDI) were conducted with stakeholders purposely selected from a variety of organisations and sectors. We used a policy analysis framework to explore issues of actor power, ideas (how the issue is perceived and portrayed), context, and policy characteristics (including the severity of the problem and the availability of effective interventions), to understand: (1) why some of the Best Buys have succeeded in gaining political and policy attention; (2) why other Best Buys are absent from the current policy response; (3) what explains policy content and its characteristics (particularly in relation to questions of authority, accountability, rights-based approaches, etc); and (4) what it would take for neglected/absent Best Buys to be higher up the current policy agenda.

The study received approval from the ethics boards of the Aga Khan University and the National Bioethics Committee, Pakistan and University College London, UK.

OUR FINDINGS

TABLE 1. PAKISTAN'S NCD-RELATED HEALTH POLICIES: COMPREHENSIVENESS OF BEST BUYS AND POLICY EFFECTIVENESS

Best Buys: Cost-effective interventions	Present?	Authority	Accountability	Budget
Reduce salt intake through reformulation of food products and set target levels for salt in foods and meals				
• Goal to decrease salt consumption	✓	🔴	🔴	🔴
• Reformulation of food products to decrease salt	x	x	x	x
• Set target salt level in foods	✓	🟡	🟡	🔴
• 30% reduction in salt consumption	x	x	x	x
Reduce salt intake through the establishment of a supportive environment in public institutions	x	x	x	x
Reduce salt intake through a behaviour change communication and mass media campaign				
• Mass media campaign to reduce salt intake	x	x	x	x
• Behaviour change communication on salt	x	x	x	x
Reduce salt intake through front-of-pack labelling	x	x	x	x
Effective interventions Cost effectiveness of >/$100 per disability-adjusted life year averted in low & middle-income countries				
Eliminate industrial trans-fats through the development of legislation to ban their use in the food chain				
• Goal to eliminate industrial trans-fats	x	x	x	x
• Legislation to ban use of trans-fats in food chain	x	x	x	x
Reduce sugar consumption through effective taxation on sugar-sweetened beverages				
• Goal to reduce sugar intake	✓	🔴	🔴	🔴
• Taxation on sugar-sweetened beverages	x	x	x	x
Other recommended interventions				
Subsidies to increase uptake of fruits and vegetables	x	x	x	x
Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling, fiscal or agricultural policies	x	x	x	x
Limit portion and package size to reduce energy intake and the risk of overweight/obesity	✓	🔴	🔴	🔴
Implement nutrition education and counselling to increase intake of fruits and vegetables	x	x	x	x
Implement nutrition labelling to reduce total energy intake (kcal), sugars, sodium and fats	✓	🔴	🟡	🔴
Implement mass media campaign on healthy diets	x	x	x	x
Promote exclusive breastfeeding for first 6 months of life	✓	🟢	🔴	🔴

TABLE 1. KEY

Authority

- High authority
- Medium authority
- Low authority

Accountability

- Abides by key principles of accountability[7]
- A national lead/implementing agency is named and is assigned responsibility for reporting in the public domain
- No mechanism for accountability found

Budget

- Budget line item assigned to policy sub-component
- Budget line item planned but no evidence for line item identified
- No budget line item identified

POLICIES WITH BEST BUY INTERVENTIONS

Protection and Promotion of Breast-feeding and Child Nutrition Acts: Sindh (2013); Punjab (2012); Khyber Pakhtunkhwa (2015); Balochistan (2014)

Pakistan Dietary Guidelines For Better Nutrition, Government Of Pakistan-UN FAO, 2018

Pakistan Standards For Guidelines On Nutrition Labelling, Standards And Quality Control Authority Ps-2009-2017

Punjab Pure Food Rules, 2011, Government Of Punjab Health Department

Sindh Food Authority Regulations, 2018, Food Department, Government Of Sindh

FIG. 3

HIERARCHY OF POLICY AUTHORITY IN PAKISTAN

The relative level of authority of different policy documents has been categorised, which can indicate the likelihood that bureaucrats, industry and society will act on them.

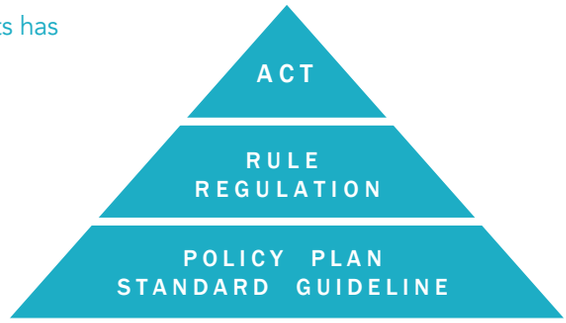


FIG. 4

HEALTH AND RIGHTS IN PAKISTAN POLICY

Rights-based policies can strengthen countries' efforts to address the determinants of NCDs. A rights-based approach has been central to progress in the AIDS response, both in ensuring that individuals are protected against discrimination and committing the State to take positive actions. We find however, that human rights language and concepts are largely absent from NCD policies.[8]

NCD POLICY

No rights, equity or gender equality language identified

HIV POLICY

"With the bulk of infection among key populations whose behaviour is criminalised and highly stigmatised, human rights and gender issues can have significant implications for strategic efforts to increase programme coverage among these groups."

"Programming should pay attention to the needs of young male sex workers... there will be youth-specific dimensions to their vulnerability that tailored programming needs to address."

"Prevention programming should be delivered in a non-judgmental and non-stigmatising way that respects client confidentiality... delivered on the basis of informed consent; the decision to get tested belongs to the client."

"Training health care workers on human rights and medical ethics can help to increase access and uptake by those in need."

Pakistan AIDS Strategy III 2017-2021

BRINGING IT ALL TOGETHER: THE POLICY CUBE

The "Policy Cube," brings together the three axes of our policy content review: 1) dietary policy comprehensiveness, or the extent to which WHO Best Buys are reflected in national policy documents; 2) the effectiveness of a policy's implementation and enforcement mechanisms, such as its level of authority, whether it has an associated budget, and whether systems of accountability are specified, and; 3) the extent to which policies are oriented towards principles of equity, gender and human rights. A full cube would represent a robust policy framework for the prevention and control of NCDs.

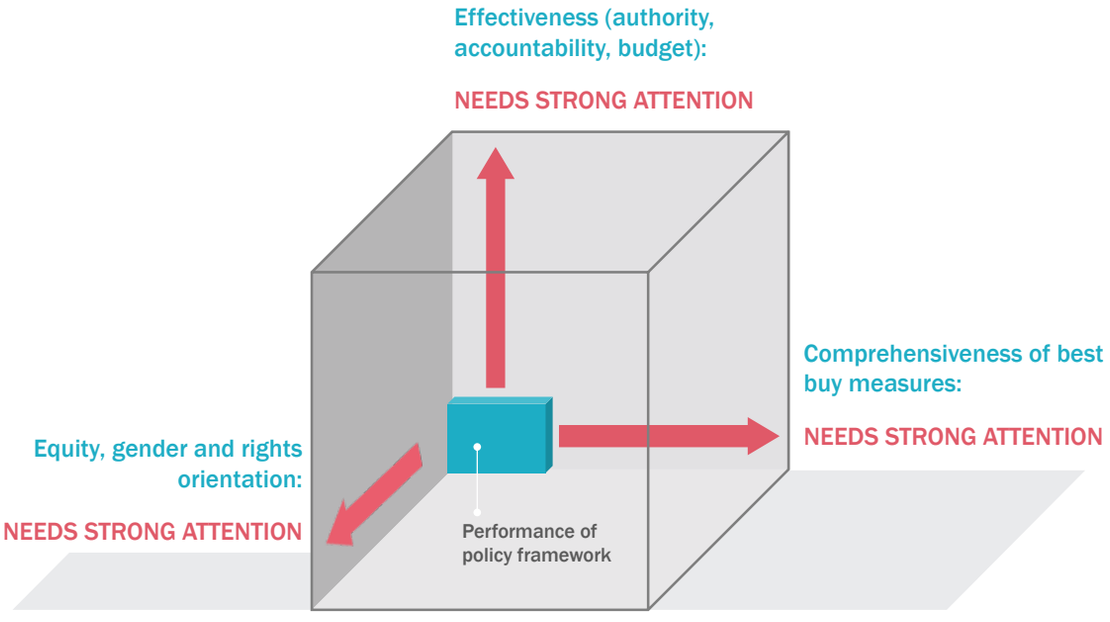
Comprehensiveness. Very few policies in Pakistan contain any of the Best Buys or other recommended interventions. None of the highly recommended Best Buys have been adopted. Some restrictions on marketing to children in schools and nutritional labelling policies exist, such as the Pure Food Rules in Punjab and Sindh Food Regulations. All provinces have formulated laws for the protection and promotion of breastfeeding.

Effectiveness. Apart from breastfeeding laws, the policies that do exist are not at the highest level of authority. For example, while the Dietary Guidelines for Better Nutrition 2018 recommend low and specific target salt levels, the recommendations are not enforceable. Further, none of the policies were found to have a specific budget, although some, such as the nutritional labelling regulations and regulations on marketing to children in schools, are part of existing programmes and can be presumed to be funded.

Equity. Vulnerable populations receive very limited consideration. While some policies target children, other groups such as the poor and people with lower access to healthy nutrition have not been prioritised in efforts to improve financial and geographical access to healthy food. In contrast to NCD policies, Pakistan's HIV policies specify key populations at higher risk of HIV. They explicitly recognise human rights violations as barriers to progress in the HIV response and mandate the protection of the rights of people living with and affected by HIV.

FIG. 5

POLICY CUBE PAKISTAN: THREE DIMENSIONS OF ASSESSING NCD POLICY FRAMEWORKS



STAKEHOLDERS WEIGH IN

INTERVIEWS WITH STAKEHOLDERS ON THE MAJOR IMPEDIMENTS TO PROGRESS IN ADVANCING THE NCD AGENDA: KEY FINDINGS

ACTOR POWER
Lack of political attention and financial support for dual faces of malnutrition

> We have a double burden of malnutrition in Pakistan, but we are dealing with deficiencies only. We are not dealing with obesity, hypertension etc. because of lack of attention and finance. The government's initiative on NCDs is not there.
>
> *IDI 25 & 26, Manager and Program Policy Officer, Health Department*

ACTOR POWER
Weak regulation of the dietary environment

> Food Industries are not certified. There is a very bad system being followed in small bakeries, where there are no checks and balances. They are adding non-food items. There are no laws, anyone can make whatever they want in their factories.
>
> *IDI 18 & 19, Consultant Research & Development, Food Industry*

IDEAS
Lack of policy attention to NCDs due to absence of dietary surveys

> Whatever we are doing is just following others. We don't know what people are eating in Pakistan. Epidemiology comes later when we ask what is the diet-related disease relationship. That is the next step - but at this first step we don't know what our people are eating. We don't know the trends. We do not have food consumption surveys here.
>
> *IDI 22, Academic affiliated with World Public Health Nutrition Association*

IDEAS
Need to raise awareness to influence individual behaviour change

> The most important thing is awareness, both before and after disease develops. For the majority of our community, to deviate from their acquired taste is very difficult... unless the person realises that instead of two spoons, they should use one spoon (of sugar). Whatever law you pass, their implementation has to take place in the household.
>
> *IDI 13, Health Department Representative*

POLITICAL CONTEXT
Absence of coordination between Health and Food Departments

> Our mandate is to ensure the safety and quality of food, that these are not hazardous... It is not the job of the food authority to find out where the disease is coming from. This is the job of the health department.
>
> *IDI 10 & 11, Food Department Representatives*

> There is no focus on nutrition. Multiple departments are involved but the different departments do not talk to each other because no minister wants interference. The various departments are not coordinating.
>
> *IDI 32, High-level Health Department Official*

RECOMMENDATIONS

The following recommendations arise from our policy analysis and stakeholder interviews. They should be considered as a strategic package of elements that are mutually reinforcing and interdependent, and require the engagement of a range of identified stakeholders.

1. **Generate evidence on diet and NCD burdens and trajectories.** Expand comprehensive STEPS surveys of dietary risk behaviours and National Nutrition Surveys to all provinces with the support of WHO and UNICEF.

2. **Institutionalise coordination platforms at national and provincial levels.** Create a multi-sectoral body on NCDs under the leadership of the Ministry of Planning, Development and Reform in all provinces with dedicated budgets, and involve health, food, information, education and finance ministries as well as representatives from industry, academia and civil society.

3. **Embed WHO recommendations in policies across relevant sectors.** Develop multi-sectoral NCD policies, with targets for reductions of salt and sugar and elimination of trans-fats, that incorporate sectoral and cross-sectoral funding, implementation mechanisms and systems of accountability.

4. **Adopt provincial legislation.** Legislative and regulatory measures should be instituted by all provinces to eliminate trans-fats, limit salt and sugar content and limit portion sizes of packaged foods and sugary beverages.

5. **Conduct a mass media campaign.** The Ministries of Health, Information & Broadcasting and the nutrition cell in the Ministry of Planning and Development should run an evidence-informed mass- and multi-media campaign with widespread cultural appeal, to create awareness around healthy eating and cooking practices.

6. **Forge an advocacy coalition.** Encourage experts, public health practitioners and civil society organisations to develop a deliberate and coordinated strategy to: 1) Advocate with and provide support to government to ensure WHO Best Buys are reflected in policy (even in the face of industry opposition); 2) Encourage industry to reformulate foods and stop promotion efforts targeted at children, and; 3) Advocate with development partners at global and national levels to address the double burden of malnutrition (i.e. both under- and over-nutrition) in the country.

7. **Embed rights and equity in NCD policies.** Ensure that future NCD policies utilise the potential of human rights approaches and concepts to ensure greater accountability for evidence-informed, gender-responsive and equitable outcomes, as is the case in the AIDS response.

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[7] Key principles of accountability, namely: i) a national lead/implementing agency is named and is assigned responsibility for reporting in the public domain; ii) a mechanism for independent monitoring of progress on implementation is described; and iii) remedial actions/sanctions/fines are outlined if implementation progress does not occur. From: Williams C, Hunt P. (2017). Neglecting human rights: accountability, data and Sustainable Development Goal 3, The International Journal of Human Rights; DOI:10.1080/13642987.2017.1348706.

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